

UNDERSTANDING HEALTH CARE REFORM

Agenda

- **Top 5 Benefits of Health Reform Legislation***
- **Benefits of Health Reform to Montana**
- **Immediate Benefits**
- **Discussion of Key Provisions**
- **What's NOT in the Health Reform Bill**

** References to health reform legislation include provisions from the Patient Protection and Affordable Care Act and the Health Care & Education Reconciliation Act*

Top Five Benefits of Health Reform Legislation

1. **End Insurance Company Abuses:** When fully implemented, health reform will end insurance company abuses such as rescissions, medical underwriting, pre-existing condition exclusions and volatile premium increases.
2. **Health Coverage for the Uninsured:** By 2019, health reform will provide coverage to 32 million Americans who are currently uninsured.
3. **Focus on Prevention and Quality:** Health reform focuses on prevention and wellness – and the notion of personal responsibility. Reform also begins to move our health system away from paying for the quantity of services provided and toward a system focused on accountability for better quality and outcomes.
4. **Strengthen Medicare:** Health reform guarantees Medicare benefits will remain available and in fact will strengthen Medicare by closing the prescription drug coverage gap (the “donut hole”), fighting fraud, waste, and abuse, reducing premiums and co-pays for seniors, and extending the life of the Medicare trust fund by a decade.
5. **Deficit Reduction:** Health reform will reduce the deficit by \$143 billion over the next ten years and by as much as \$1 trillion in the following decade.

Benefits of Health Reform to Montana

- Starting this year, more than 24,000 Montana small businesses will be eligible for tax credits for a percentage of their contribution to their employees' health insurance
 - Small businesses of the size that qualify for these tax credits employ 88,356 Montanans
- This year, 28,400 Montana seniors who hit the gap in drug coverage will be eligible for a \$250 rebate, and starting next year we will begin to close the “donut hole” completely
- Health reform will improve Medicare benefits for 160,000 Montana seniors
 - Next year, Medicare beneficiaries are eligible for a free annual wellness visit and preventive services
 - Also next year, Medicare premiums will be reduced for the 134,000 Montana seniors who are not enrolled in Medicare Advantage but are subsidizing these private insurance plans through overpayments
- This year, health reform will provide access to health coverage for as many as 21,978 uninsured Montanans who are unable to obtain health insurance because of a pre-existing condition
 - Beginning in 2014, health reform will ensure affordable coverage options for 159,000 Montanans who are uninsured and 79,000 Montanans who purchase health insurance through the individual market
- Beginning in 2014, insurance market reforms will reduce health insurance premiums by \$1,440 - \$2,050 for the same family policy through increased efficiencies and greater competition
- In addition, in 2014, 93,200 Montanans will receive premium tax credits to help make health insurance even more affordable
 - In the first five years the health insurance Exchange is operational, Montanans will receive \$1.5 billion in premium and cost-sharing tax credits to further reduce the cost of health insurance

Immediate Benefits

- Provides small business tax credits up to 35% of premiums beginning in 2010
- Provides coverage and federal subsidies through a high risk pool for uninsured individuals with pre-existing conditions beginning July 2010
- Bans lifetime limits on coverage, unreasonable annual limits, and rescissions, and precludes exclusions for kids with pre-existing conditions effective for plan years beginning six months after enactment
- Extends coverage for young adults by allowing adult children up to age 26 to remain on family policies beginning six months after enactment
- Establishes a reinsurance pool to lower premiums for retirees beginning July 2010
- Promotes transparency in the insurance market by requiring a minimum Medical Loss Ratio that guarantees most premium dollars are spent on health care, not administrative expenses, beginning in 2011
- Sends a \$250 rebate check to Medicare beneficiaries who hit the “donut hole” in 2010
 - Begins to fill in donut hole for brand and generic drugs in 2011
- Promotes primary care by giving physicians in Medicare a 10% payment bonus
- Promotes prevention and wellness by providing free preventive benefits and an annual wellness visit in Medicare beginning in 2011 and requires new health insurance plans to cover prevention and wellness benefits beginning six months after enactment

Key Health Insurance Market Reforms

2010

- **High Risk Pool:** \$5 billion set aside to provide access to insurance and subsidize premiums for uninsured individuals with pre-existing conditions until coverage through Exchanges is established in 2014
- **Early Retirees:** \$5 billion to reduce premium costs for early retirees (55-64) and support employer-based coverage by giving employers up to 80% of costs between \$15,000 and \$90,000 for high cost retiree claims
- **Market Reforms:** Starting plan year beginning six months after enactment:
 - Coverage for adult children up to age 26 and free preventive benefits in new private plans
 - No lifetime limits, restricted annual limits, no rescissions, no pre-existing condition exclusions for kids

2011

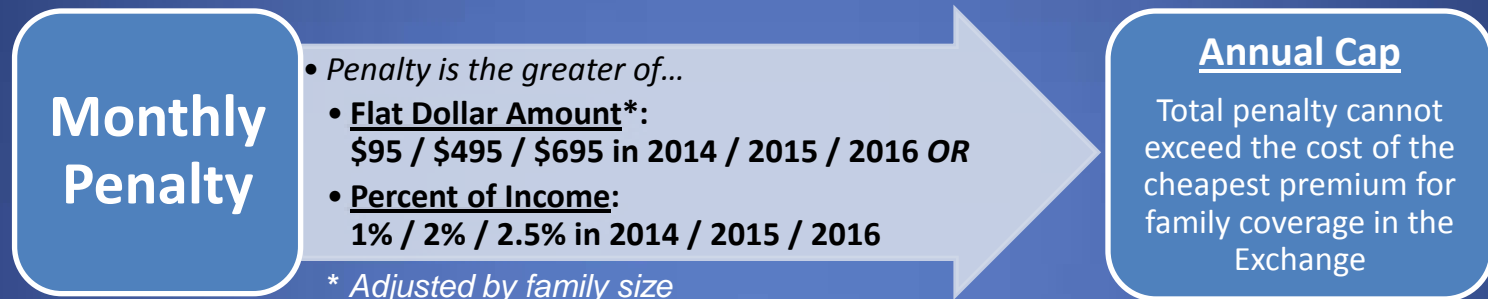
- **Rate Review:** Insurers will be required to disclose and justify premium increases
- **Medical Loss Ratios:** Insurers must spend 80% of premium dollars on health benefits in the individual and small group markets and 85% in the large group market or pay rebates back to consumers for the difference

2014

- **Market Reforms:** Guarantee issue, adjusted community rating, limits on rating based on tobacco use, prohibition on annual limits and discrimination based on health status, coverage of essential health benefits, new out of pocket cost limits, and limits on waiting periods imposed by employers
- **Shared Responsibility:** Exchanges, employer and individual responsibility provisions, and premium tax credits for purchasing insurance all take effect

Individual Responsibility

Starting in 2014, individuals must have health insurance or face a penalty



Exceptions to the Individual Responsibility Requirement

No Mandate	No Penalty
Religious Conscience (based on Medicare and IRC)	Unaffordable (premiums >8% of income)
Immigrants not lawfully present in the U.S.	Income below tax filing threshold
Incarcerated Individuals	American Indians
Minimum essential coverage (Medicare, Medicaid, TRICARE, CHIP, VA, employer, individual, grandfathered)	Those without coverage less than 3 months

Employer Responsibility: Busting Common Myths

- Fact:** Employers with fewer than 50 FTEs are not required to provide coverage and not subject to a penalty.
- Fact:** Employers are not required to offer health coverage *per se*, but if they do not provide coverage and workers use federal tax credits, then they must pay a 'free rider' penalty.
- Fact:** Penalties do not apply to part-time workers (although the calculation of FTE includes part-time workers).
- Fact:** Employers that do offer coverage are not required to meet the definition of "essential health benefits" and are not required to subsidize a certain proportion of the premium.
- Fact:** Employers offering coverage that is deemed 'unaffordable' may pay a penalty if workers use federal tax credits.
- Fact:** Employers are not responsible for keeping track of which employees have health insurance for purposes of meeting the individual requirement.

Benefits of Reform to Small Business

- Starting in 2010, a small business tax credit is available for employers contributing at least 50 percent of the total premium cost of health insurance for their employees:
 - Sliding scale credit for health insurance premiums to small employers with fewer than 25 employees and average annual wages of less than \$50,000. Full credit available to employers with 10 or fewer employees and average annual wages of \$25,000 or less.
 - In 2010-2013, the small business tax credit is worth up to 35% of an employer's contribution to employee plan (25% for tax exempt small businesses)
 - Beginning 2014, small businesses can receive tax credits for two years worth up to 50% of an employer's contribution to employee plan (35% for tax exempt small businesses)
- Small Business Health Option Program (SHOP) – Beginning in 2014, new health insurance exchanges are open to small businesses with up to 100 employees
 - These exchanges will enable small firms to compare and shop for health insurance more easily
 - Insurance market reforms applied to small businesses will prevent steep increases in premiums year to year

Impact of Health Reform on States

- Beginning in 2014, Medicaid will expand to cover all non-elderly individuals below 133% FPL (\$14,400 for an individual, \$29,300 for a family of 4)
 - Federal matching rate for newly eligible populations will be 100% in 2014-2016, 95% in 2017, 94% in 2018, 93% in 2019 and 90% in 2020 and beyond
- States are required to maintain current Medicaid eligibility levels for adults until January 1, 2014
 - Exception to maintenance of effort: States experiencing a budget deficit or expected to be in a budget deficit may scale back eligibility levels for non-pregnant, non-disabled adults to 133% FPL prior to 2014
- States are required to maintain current Medicaid and CHIP eligibility levels for kids until September 30, 2019 and will see a 23 percentage point increase in their CHIP match rates from FY2016 through FY 2019
- The Medicaid drug rebate will increase to 23.1% and will apply to Medicaid managed care organizations
- Reduces Federal Medicaid DSH allotments by \$18.1 billion from 2014 to 2020

Options and Opportunities for States Under Health Reform

- **Health Insurance Exchanges**

- Each state can establish and operate its own insurance Exchange through which new health insurance options in the individual and small group will be offered.
- States can expand exchanges to include the large employer market.
- States have the authority to bar insurance companies from the Exchange if premium increases are too high.
- States can also establish multi-state Exchanges to allow insurance to be purchased across state lines.

- **Interstate Compacts to Sell Insurance Across State Lines**

- States can ban together through interstate compacts to sell insurance across state lines.

- **Consumer Operated and Oriented Plan (CO-OP) Program**

- \$6 billion in Federal funding is available for grants and loans to start non-profit, member-run insurance cooperatives.

- **“Basic Health Plan”**

- Health reform gives States the option to establish basic health plans for non-Medicaid eligible individuals with incomes up to 200% of poverty as an alternative to private health insurance.

- **Opt-Out**

- States can choose to implement an alternative health care reform program by applying for a waiver, but must provide comparable levels of coverage within budget targets. For example, states can pursue a single payer option or a pure private health system.

Health Reform Promotes Cost Containment

- Health reform imposes a fee on insurance companies offering high-cost “Cadillac” plans, which will drive down the cost of these plans over time
- Health insurance market reforms will streamline the market:
 - Ensures premiums go towards health care not administrative costs or profits
 - Promotes competition and choice through the new health insurance Exchange
 - Reduces insurance company bureaucracy and paperwork
 - Empowers consumers by reporting health benefits on W-2 forms
- Reform will improve the health care delivery system by focusing payment on quality and value rather than volume
- Included in health reform is a new Independent Payment Advisory Board (formerly known as “Medicare Commission”) with teeth to control costs
- Reduces federal deficits
 - \$143 billion over next ten years
 - Up to \$1 trillion in the second decade

Health Reform Achieves Delivery System Reform

- The health reform bill includes initiatives to re-orient the health system toward paying for quality over quantity and to encourage health providers to work together to better coordinate patient care.
- **Key proposals include:**
 - Rewarding high-quality providers through Value-Based Purchasing (hospitals, physicians and other Medicare providers)
 - Establishing Accountable Care Organizations and payment bundling that reward doctors and hospitals that work together to improve quality and efficiency
 - Policies to reduce hospital-based infections and avoid costly readmissions to the hospital
 - Comparative Effectiveness Research to better inform doctors and patients about what treatments work best
 - CMS Innovation Center to find the next generation of delivery system reforms
 - Independent Payment Advisory Board (IPAB) to further strengthen Medicare and extend payment reforms to the private sector

Administrative Simplification Will Benefit Health Care Providers

- Requires insurance companies to adopt uniform standards and business rules for electronic transactions that occur routinely with health providers
- Examples of benefit to health care providers:
 - A doctor wants to verify eligibility for benefits and/or tests with an insurance company at the time of a visit
 - A hospital needs prior authorization from the insurance company before it can perform tests or procedures during a hospital stay
 - A doctor or hospital wants to get paid from the insurance company via electronic funds transfers instead of paper checks
- Insurers that don't comply with the new standards will pay a penalty
- Making electronic transactions uniform will make it easier—and cheaper—for doctors and hospitals to do business with insurance companies and reduce health care costs throughout the system

Health Reform Places Greater Emphasis on Prevention and Wellness

- Improves federal coordination of and outreach and education about preventive services
- Creates a \$15 billion Prevention Trust Fund
- Eliminates cost-sharing for recommended preventive care in Medicare, creates incentives to do so in Medicaid
- Requires first-dollar coverage for preventive services in the Exchange and new employer-based plans
- Permits higher premiums for smokers in the Exchange
- Allows workplace wellness programs to vary premiums by up to 30%
- Requires chain restaurants and vending machine food operators to disclose nutritional information

Impact of Health Reform on Medicare Advantage

- Eliminates wasteful overpayments to private insurance companies in the Medicare Advantage program
 - New payments are sufficient for insurers to participate in rural and urban areas
 - Insurers that deliver high quality care and good customer service will get bonus payments
- Protects enrollees in Medicare Advantage plans
 - Prohibits private insurers from charging higher copayments than fee-for-service Medicare for services like chemotherapy and skilled nursing care
- Guarantees better value from Medicare Advantage plans
 - Require private insurers that spend less than 85% of premiums on medical claims to report to Medicare and send rebates to Medicare trust funds if excessive administrative costs continue

Impact of Health Reform on Medicare Part D

- Immediately begins to fill the Part D coverage gap or “donut hole”
 - In 2010, gives a \$250 rebate check to any senior who hits the donut hole in 2010
 - In 2011, provides a 50% discount on brand-name drugs in the gap
 - In 2013, provides even more coverage for brand-name drugs and begins coverage for generics in the gap
- Moves the annual open enrollment period to October 20th through December 7th (from Nov 15-Dec 31) beginning in 2012
- Increases funds for the State Health Insurance Assistance Program (SHIPs) and other community outreach programs
- Improves Part D for seniors with low incomes:
 - Increases availability of Part D plans at \$0 premium for beneficiaries with low income
 - Closes loopholes that make widows and widowers ineligible for low-income assistance
 - Ensures low income seniors receive formulary information if they are assigned to new Medicare drug plans

Health Reform Benefits Native Americans

- Reauthorizes the Indian Health Care Improvement Act
- Indians are subject to the individual responsibility requirement to purchase coverage but are exempt from the penalty
- No cost-sharing required for health care services provided to Indians at or below 300% FPL whether in public or Exchange coverage
- Facilitates enrollment in public programs by making tribes Express Lane agencies
- Continued payment for all Medicare Part B services furnished by IHS
- Tribal governments are included in all councils and boards, as well as references to local government
- Health services and coverage provided by a tribe to a tribal member is tax free to the member

Health Reform Takes Steps to Improve Medical Malpractice Resolution

- Includes the Baucus-Enzi “Fair and Reliable Medical Justice Act,” which provides demonstration grants to states for the development, implementation, and evaluation of alternatives to civil litigation. The alternatives must:
 - Make the medical liability system more reliable and accessible by increasing the availability of prompt and fair resolution of disputes,
 - Encourage the disclosure of health care errors,
 - Promote a reduction in health care errors and encourage early disclosure of errors,
 - Improve access to liability insurance,
 - Allow for collection and analysis of patient safety data related to disputes,
 - Provide for an appeals process and/or access to civil litigation system, and
 - Not conflict with a state law in a way that would prohibit the adoption of alternatives to tort litigation
- Gives states flexibility to design what works best for them

Major Revenue Provisions

- Excise tax on high cost employer-sponsored health coverage
 - Excise tax of 40% on insurance companies and plan administrators for health plan above the threshold of \$10,200 for single and \$27,500 for family coverage
 - Additional thresholds for retired individuals age 55 and older; plans that cover employees in high risk professions; firms whose health costs are higher due to the age or gender of their workers
- Medicare Tax on High Income Individuals
 - Increases the employee portion of the hospital insurance (HI) tax rate to 2.35% on an individual taxpayer earning over \$200,000 / \$250,000
 - Expands the HI tax to include a 3.8% tax on unearned income (income from interest, dividends, annuities, royalties and rents not derived in the ordinary course of trade/business) on taxpayers with income above \$200,000 / \$250,000
 - Excludes active S corporation or partnership income and most retirement payments
- Industry Fees
 - Fee on manufacturers and importers of brand name pharmaceuticals
 - Excise tax on the sale of medical devices (but not including those purchased by the public at retail)
 - Fee on health insurance providers

Other Revenue Provisions

- Standardize definition of qualified medical expenses
- Increase tax for using HSA funds for non-medical expenses
- Cap health FSA contributions at \$2,500, indexed for inflation
- Increase threshold for claiming itemized deduction for medical expenses
- Eliminate “double-dip” deduction for employer Part D subsidy
- Create simple cafeteria plans for small businesses
- Limit compensation for insurance company executives
- Strengthen requirements for non-profit hospitals
- Tie special deduction for Blue Cross/Blue Shield plans to minimum medical loss ratios

What's NOT in Health Reform

MYTH: Health Reform amounts to a government takeover of the health care system

FACT: Health reform builds on our current public-private system and maintains the current balance between government and private spending. And health reform does not include a public option.

MYTH : Health Reform will lead to rationing of health care and medical decisions made by government bureaucrats

FACT: Health reform maintains the doctor-patient relationship and, in fact, will provide better information to both doctors and patients about available treatment options and the effectiveness of different procedures and services.

MYTH : “Death panels” are buried in the fine print of the new health reform law

FACT: The final legislation does NOT include any provisions regarding payment to Medicare providers for voluntary end-of-life counseling.

MYTH: Health reform cuts Medicare benefits and will harm seniors

FACT: Health reform strengthens Medicare by closing the coverage gap in prescription drug benefits (the “donut hole”), adding prevention and wellness benefits, improving quality and extending the life of the Medicare trust fund by 10 years.

MYTH : Illegal immigrants will benefit from health reform

FACT: Immigrants who are not lawfully present in the U.S. are barred from receiving tax credits for health coverage or Medicaid and are prohibited from purchasing coverage through the Exchange.

MYTH : Federal taxpayer dollars will subsidize abortion

FACT: Health reform preserves current law that prohibits federal funding of abortion except in limited circumstances by requiring plans that offer abortion services to segregate premium payments for this coverage from other health coverage. The law also permits states to prohibit plans participating in the Exchange from providing abortion coverage.

MYTH : Failure to buy health insurance will result in jail time

FACT: The health reform law explicitly prohibits incarceration for failing to purchase insurance.

What's NOT in Health Reform (part 2)

MYTH: 150,483 Montana Medicare beneficiaries will lose access to doctors, hospitals and nursing homes because of the \$500 billion in Medicare cuts and the failure to address the physician payment issue

FACT: AARP, the AMA, the American Hospital Association, and nursing homes across the country support the health reform law because it strengthens the Medicare program for seniors and taxpayers. Health reform improves Medicare by closing the Part D “donut hole,” improving coverage of preventive benefits, and extending the life of the Medicare trust fund by a decade. A Republican-led filibuster blocked a permanent fix to the Medicare physician payment issue in October but Democrats remain committed to enacting a long-term doctor’s fix .

MYTH: According to the Congressional Budget Office, Medicare Advantage enrollees will see their benefits reduced by half

FACT: This is 100% false. The changes to Medicare Advantage do NOT change the core benefits that Medicare beneficiaries are guaranteed by law. Moreover, private plans are currently paid 114% of traditional Medicare rates. Health reform eliminates these overpayments by 2014—which will strengthen the financial status of Medicare and lower Part B premiums for all beneficiaries by \$4 per month.

MYTH: Health reform will increase insurance premiums for individuals purchasing coverage in Montana by 60 percent

FACT: Premiums will decrease by 14 to 20 percent for the same plan in the individual market due to market efficiencies and tax credits created by health reform.

MYTH: Premiums for Montana’s small businesses are expected to go up 19 percent

FACT: Premiums will decrease by up to 2 percent for the same plan in the individual market when the Exchange is established due to new efficiencies in the market and small business tax credits.

MYTH: Montana small businesses employing 50 or more people will either pay higher health care costs or an additional tax because of new government mandates

FACT: Small employers will have access to new, more affordable health plans because insurance companies will compete against each other to serve these firms in the new Exchanges, and premiums will be more stable.

MYTH: The 456,100 people in Montana with employer sponsored health insurance, and 68,500 people with individual health insurance now will have to pay more for their insurance because of new mandates

FACT: Health reform will bring higher quality coverage and efficiencies to the insurance market. The Congressional Budget Office estimates that premiums will be lower for employer health coverage and for most individuals and families in the individual market. Premiums will also be more stable and the system will be more fair by prohibiting insurers from discriminating against pre-existing conditions and rescinding policies when someone gets sick.

Health Resources and Services Administration

Healthy Communities, Healthy People



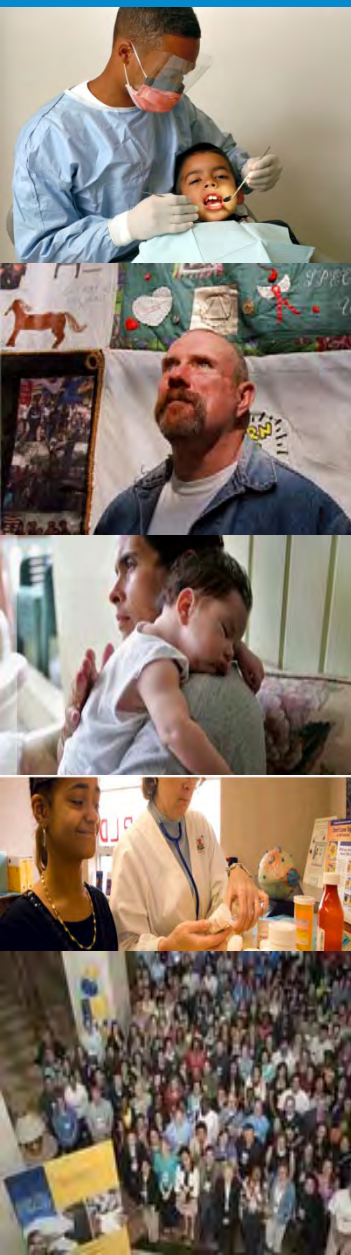


The Programs We Deliver

- ✓ Community Health Centers
- ✓ National Health Service Corps
- ✓ Workforce Training for Primary Care, Public Health, Medicine, Dentistry, Nursing, and Geriatrics
- ✓ Workforce Diversity
- ✓ Children's Hospital GME
- ✓ Practitioner Databanks
- ✓ Maternal and Child Health
- ✓ Healthy Start
- ✓ Stop Bullying Now!
- ✓ Poison Control
- ✓ Ryan White HIV/AIDS
- ✓ Rural Health Policy & Programs
- ✓ Telehealth
- ✓ Health Care for the Homeless
- ✓ Migrant Health Centers
- ✓ Native Hawaiian Health
- ✓ Vaccine Injury Compensation
- ✓ Hansen's Disease (Leprosy)
- ✓ 340B Drug Pricing
- ✓ Organ Donation & Transplantation
- ✓ And more...

The People We Serve

- Nearly 19 million patients are served through HRSA-funded health centers, including 1 in 3 people with incomes below the poverty level.
- Over 500,000 people living with HIV/AIDS receive HRSA's Ryan White services. Two-thirds are members of minority groups.
- 34 million women, infants, children, and adolescents benefit from HRSA's maternal and child health programs.
- About 14,000 safety net providers participate in HRSA's 340B program that provides access to discount drug purchases.
- Currently more than 6,700 National Health Service Corps clinicians are (or will be) working in underserved areas in exchange for loan repayment or scholarships.





HRSA and the Affordable Care Act



HRSA and the Affordable Care Act

- Increasing Access to Primary Care Services
- Investing in the Health Care Workforce
- Supporting Maternal and Child Health
- Broadening Access to 340B Drug Discounts



HRSA and the Affordable Care Act

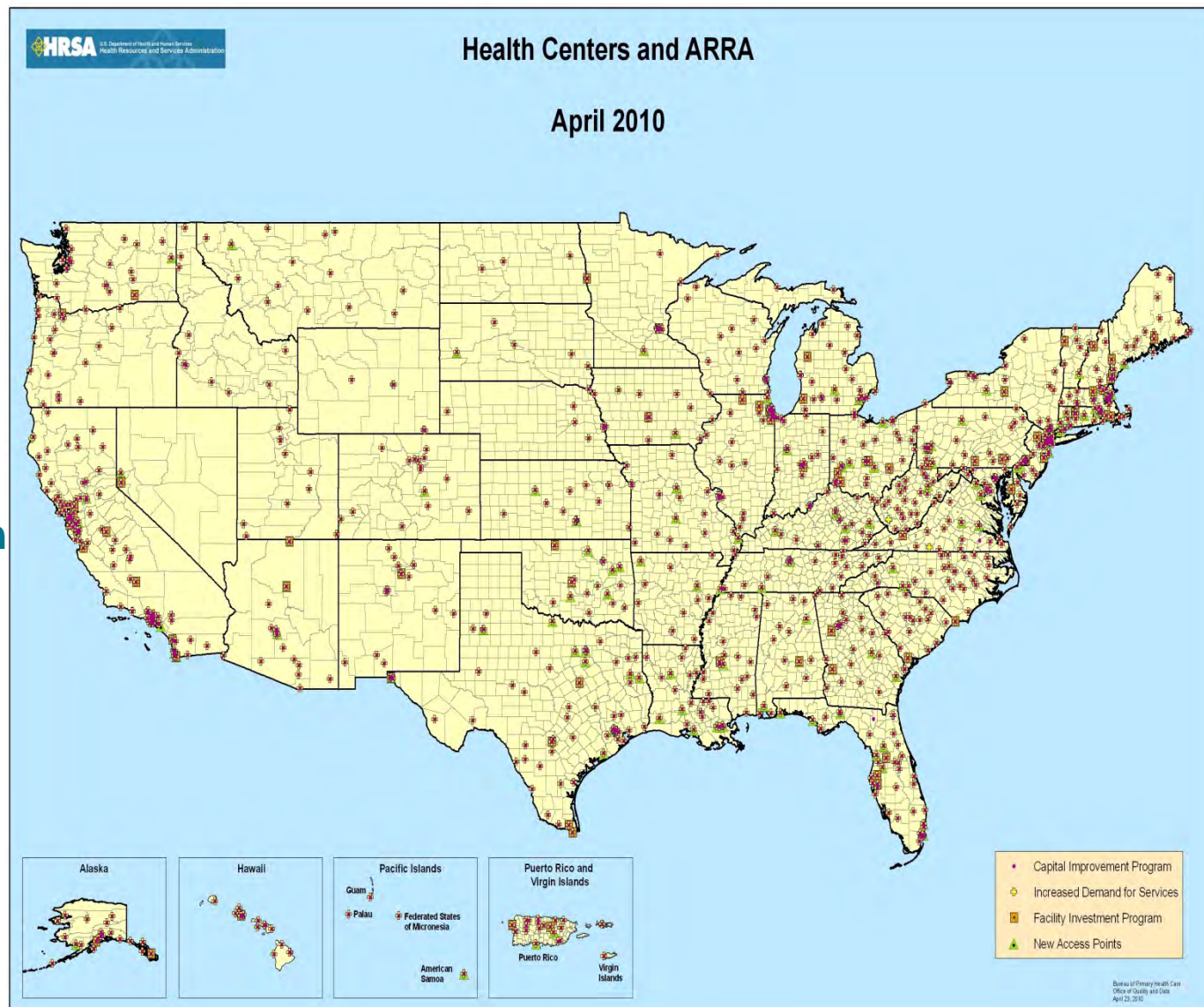
- HRSA has been identified as the lead for more than 50 provisions in the new law.
 - 19 of the provisions have immediate activities to implement in FY2010.
- 34 of the provisions have authorization for activities in FY2011 and beyond.
- There are several provisions where HRSA has been identified as a key partner with other agencies.

The Affordable Care Act Builds on HRSA Recovery Act Funding

**\$2 billion:
Community Health
Centers**

**\$300 million:
National Health
Service Corps**

**\$200 million:
Health
Professions**





Increasing Access to Primary Care Services



Community Health Centers

- The Affordable Care Act provides \$11 billion in funding over the next 5 years for the operation, expansion, and construction of health centers throughout the Nation.
- \$9.5 billion is targeted to:
 - Create new health center sites in medically underserved areas.
 - Expand preventive and primary health care services, including oral health, behavioral health, pharmacy, and/or enabling services, at existing health center sites.
- \$1.5 billion will support major construction and renovation projects at community health centers nationwide.
- This increased funding will double the number of patients seen by health centers, making primary health care available for an additional 20 million people.



Investing in the Health Care Workforce



National Health Service Corps

The Affordable Care Act Builds on:

Significant Program Expansion

- \$300 million in expansion funds for the NHSC from the Recovery Act
- More than 6,700 clinicians presently serving
- 7,358 Primary Care Providers estimated in 2010 vs. 4,760 in 2009
- Over 8,600 NHSC-Approved sites; 46% Community Health Centers

Recent Program Improvements

- Simplifying the NHSC site application and approval process.
- Examining NHSC disciplines to ensure the primary care workforce needs are supported.
- Assessing NHSC program implementation with the goal of driving more people into primary health care careers to meet public needs.

National Health Service Corps and the Affordable Care Act

- Reauthorization of NHSC Program through 2015
- Increases Maximum Loan Repayment Award from \$35,000 to \$50,000
- Allows for Half-Time Opportunities; 2 & 4 Year Contracts
 - Expanded to Include Loan Repayment & Scholarship Programs
- NHSC Funding in the Community Health Center & NHSC Fund
 - FY2011: \$290 million
 - FY2012: \$295 million
 - FY2013: \$300 million
 - FY2014: \$305 million
 - FY2015: \$310 million

Health Professions Education and Training

- Primary Care Training: Title VII, Sec 747
 - Develop and operate family, general internal and pediatric medicine programs; research; need-based fellowships/traineeships; new interdisciplinary joint degree program and community-based training for faculty.
- Oral Health Training: Title VII, Sec 748
 - Program development, financial assistance; new faculty loan repayment program; expands programs to public health dentistry and dental hygienists.
- *New rural physician training grant program*
 - Published an Interim Final Rule on 5/21 defining “underserved rural community” for this program.



Support and Incentives for Student and Providers

- *Area Health Education Centers* - program name change; activities to educate and recruit high school students; innovative activities; reduces match requirement.
- Geriatrics - expanded career incentives and discipline eligibility for current programs, traineeships for advanced education nurses.
- Public health and health administration - tuition, fees, stipends for traineeships.
- Preventive medicine residency program expanded eligibility.
- Nursing - training advance practice nurses and family nurse practitioners; enrollment of disadvantaged students; retention, stipends, loans.



Delivery System Provisions

- Nurse Managed Health Centers
 - Establishes funding for community-based clinical sites administered by advance practice nurses and increases primary care sites.
- Patient Navigator and Chronic Diseases Outreach Grant
 - Program requirement for minimum core proficiency standards
 - Includes \$5 million in FY2010 to fund community workers trained to assist patients and families in managing chronic conditions such as diabetes and cancer.
 - Application due date in June and awards will be made in September 2010.
- Teaching Health Center Grants
 - Expands community-based training for primary care physicians.
 - FY2010 – 2015 \$230 million



Shortage Designation

- Instructs HRSA to redesign the Medically Underserved Areas (MUA) and Health Professional Shortage Areas (HPSA) designation process through negotiated rulemaking.
- HRSA Published a Federal Register Notice on 5/11 seeking public input on whether HRSA has:
 - Properly identified the key issues in this designation rulemaking effort;
 - Adequately identified key sources of subject matter technical expertise relevant to defining underservice and shortage and designating underserved areas and populations; and
 - Identified appropriate representatives of the various stakeholders/interests that will be affected by the final designation rules.
- Comments are due by 5pm on June 10.



New Workforce Programs Authorized

- *Mid-career scholarships*
- Public health loan repayment
- Cultural competency, prevention and public health and individuals with disabilities training
- Expanded public health training fellowships
- *Geriatric workforce development fellowships*
- New program for individuals to apply for and receive loan repayments if serving as nurse faculty
- Develop and implement programs to provide education and training in pain management
- *Family and direct caregiver training*
- *Alternative dental health care providers demonstration project*
- Mental and behavior health education and training



Supporting Maternal and Child Health



Maternal, Infant, and Early Childhood Home Visiting Program

- The Affordable Care Act creates a Maternal, Infant, and Early Childhood Home Visiting Program to fund States to provide evidence-based home visitation services to improve outcomes for children and families who reside in at-risk communities.
- Funding in FY2010 is \$100 million.
- Home visiting is a strategy that has been used by public health and human services programs to foster child development and address problems such as infant mortality.
- HRSA and ACF are working collaboratively on this program.



Family-to-Family Health Information Centers

- HRSA grants support Family-to-Family Health Information Centers -- non-profit organizations that help families of children and youth with special health care needs and the professionals who serve them.
- The Affordable Care Act extends the Family-to-Family Health Information Centers program by appropriating \$5 million each year through FY2012. Funding helps families:
 - Learn about and secure adequate insurance coverage and benefits
 - Navigate the health care system
 - Understand the information needed to discuss needs with their health care providers.



Broadening Access to 340B Drug Pricing and Other HRSA Programs



340B Drug Pricing Program

- The Affordable Care Act amends the 340B program to add the following to the list of covered entities that are entitled to discounted drug prices:
 - Certain children's and freestanding cancer hospitals excluded from the Medicare prospective payment system
 - Critical access and sole community hospitals
 - Rural referral centers
- Requires the Secretary to develop systems to improve compliance and program integrity activities for manufacturers and covered entities, as well as administrative procedures to resolve disputes.
- Also requires a GAO Study on Improving the 340B Program, due within 18 months of enactment to make recommendations on whether the program should be expanded.

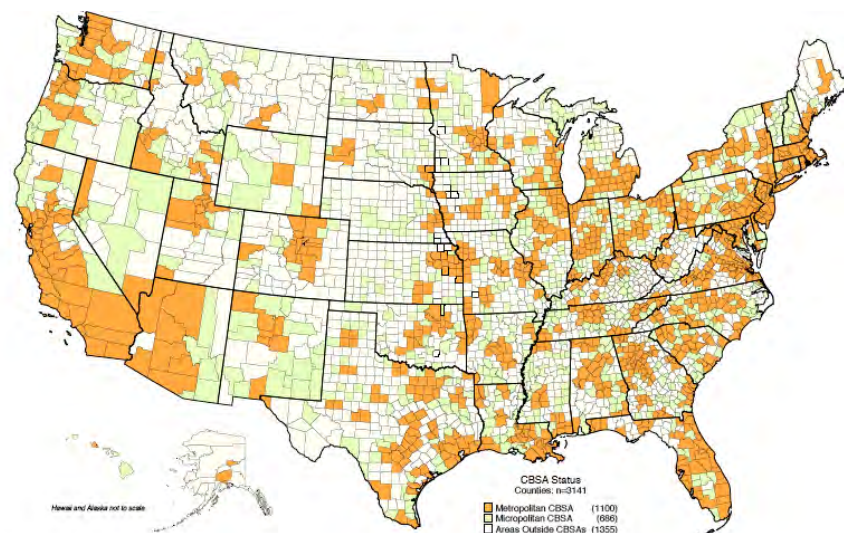
Trauma Care

- The Affordable Care Act adds the new trauma care programs.
 - \$100 million authorized for three programs to award grants to qualified public, nonprofit Indian Health Service, Indian tribal, and urban Indian trauma centers.
- ACA also authorizes \$100 million to establish a program of grants to States to promote universal access to trauma care services provided by trauma centers and trauma-related physician specialties.

Rural Programs and the Affordable Care Act

Supporting the Rural Infrastructure

- Payment Extensions
- 340B Changes
- Value-Based Purchasing Demonstration for Critical Access Hospitals
- Low-Reimbursed Rural Hospital Payments
- Frontier Wage Index & Practice Expense Floor
- Low-Volume Adjustment Changes
- Medicare-Dependent Hospital Extension
- Expansion of the Regional Extension Assistance Center for HIT (REACH) Demonstration





For More Information

On the Affordable Care Act, please visit:

www.healthreform.gov

On HRSA, please visit:

www.hrsa.gov

Please feel free to contact me:

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